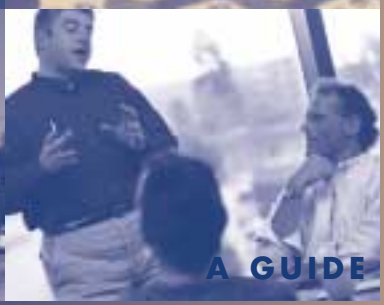
Evidence-Based Assertive Community Treatment



A GUIDE FOR MENTAL HEALTH PLANNING AND ADVISORY COUNCILS

This tool kit provides an introduction to evidence-based Assertive Community Treatment (ACT) programs. It will help state mental health planning and advisory council members and others assess the community-based programs and services offered in their state plans for people with serious and persistent mental illnesses .

Exemplary practices and resources for more information are provided to help council members use this document as a springboard for a more thorough understanding of the issue. Contact **the National Association of Mental Health Planning and Advisory Councils (NAMHPAC)** at (703) 838-7522 for more information about ACT services or to receive information about state mental health planning and advisory councils.

The Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services, definition of evidence-based Assertive Community Treatment (ACT) takes into account the body of research supporting treatment models based on the well known Program of Assertive Community Treatment (PACT). In this guide, we will use the term "evidence-based assertive community treatment" to refer to PACT and those models which have been replicated with empirically demonstrated treatment effectiveness. This broader definition is intended to recognize both the importance of using scientifically supported interventions as well as the necessity for states and communities to have flexibility in using programs adapted for their needs.

ACT is one of the most documented and effective models of integrated community care for people with serious and persistent mental illnesses. ACT is a preventive approach to mental health services that helps people avoid further hospitalization. To this end, consumers receive a full range of medical, psychosocial, and rehabilitative services where they live and work.

Through ACT, a multi-disciplinary team:

- Provides direct treatment, rehabilitation, and support services to people with severe and persistent mental illnesses;
- Refers consumers minimally to outside providers;
- Provides services on a long-term care basis;
- Delivers 75 percent or more of services outside of office settings; and
- Emphasizes outreach, relationship building and individualized services.

ACT in Action

Intensive community-based systems were developed to respond to the needs of persons leaving psychiatric hospitals. Until recently, such services were either lacking or inadequate. Even today, community-based services may not be effectively integrated or easily available. As a result, many states and communities have invested in comprehensive mental health services at the local level.

At the center of the ACT model is a community-based, multi-disciplinary team of mental health workers who provide a defined group of consumers with services. This team is responsible for assisting consumers in all areas of life. ACT staff-to-consumer ratios are low. In addition, the ACT team typically is on-call 24 hours a day for emergency treatment, provides home delivery of medications, actively monitors physical health care and has frequent contact with both consumers and their family members.

Critical elements of ACT include:

- The team is the primary provider of treatment, rehabilitation, and social services. This approach minimizes fragmentation and reduces time spent coordinating services through multiple agencies. It also ensures that someone is always available to provide a broad range of services.
- Mobile teams provide services where consumers live and work, rather than in agency settings. Teams spend over 75 percent of their time in the consumers' environments. This helps prevent dropout and provides support in settings where will be needed most.
- Highly individualized services address the constantly changing needs of mental health consumers over time. Customized treatments meet the individual's current needs rather than following preset programs.

Evidence-Based ACT Standards

In this brochure, the term evidenced-based ACT refers to PACT and ACT models whose efficacy has been documented by research. This broader definition recognizes both the need for states and communities to adapt programs and the importance of using scientifically supported interventions.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has published standards for ACT programs. They are:

Admission Criteria – Participants should be consumers with symptoms that seriously impair their functioning in commu-

nity living. Priority should be given to people with long-term psychiatric disabilities such as schizophrenia, other psychotic disorders, and bipolar disorder. In addition, participants should be consumers with high service needs such as frequent psychiatric hospitalization, coexisting substance abuse disorders, inability to meet basic survival needs, and the inability to participate in traditional, office-based services.

Discharge Criteria – Participants should be discharged from team-based services only when they move outside of the service area, demonstrate an ability to function in major roles without assistance for at least two years, or request discharge.

Service Capacity – Each team should provide at least one full-time staff person for every 10 consumers, with no more than 120 consumers served by any urban team and no more than 80 consumers served by any rural team.

Service Requirements – Teams must be qualified to provide case management; individual supportive therapy; medication prescription, administration and monitoring; substance abuse treatment; work-related services; assistance with the activities of daily living, as well as social, interpersonal, leisure, and educational activities; consultation to families; and other supports.

Staff Requirements – Urban programs should employ a minimum of 10 – 12 full-time clinical staff, one program assistant, and 16 hours of psychiatrists' time for every 50 consumers. Rural programs should employ 5–7 full-time clinical

staff persons, a half-time program assistant, and 16 hours of psychiatrists' time for every 50 consumers. The standards specify staff requirements and the necessary experience to round out the team.

Program Organization – Urban teams should be available to provide treatment, rehabilitation, and support activities seven days per week, over two eight hour shifts, and operate a minimum of 12 hours per day on weekdays and eight hours each weekend day and holiday. Teams should also operate an after-hours on-call system, and psychiatric backup should be available during all off-hour periods. Rural teams should schedule staff to provide the necessary services on a case-by-case basis in the evenings and on weekends. When a rural team cannot operate an after-hours on-call system, it should provide crisis services during regular work hours.

Evidence-Based ACT Results

The first study to evaluate an ACT approach to services was conducted in Madison, Wisconsin in the 1970s. The study found that this approach resulted in less time spent in psychiatric hospitals, better independent-living skills, improved symptomatology, enhanced work and social functioning, and higher consumer satisfaction. (Stein & Test, 1980).

Studies in other communities have also shown ACT is effective in reducing the number of days spent in psychiatric hospitals. Such studies occurred in Kent County, Michigan (Mulder, 1985), Sydney, Australia (Hoult, Renolds, Charbeonneau-Powis, Weeks & Briggs, 1983), Chicago (Bond, 1990) and Indiana (Bond, Miller, Krumwied & Ward,

1998). In addition, some of these studies found that consumers in ACT programs had fewer symptoms than their counterparts (Hoult, 1983; Stein & Test, 1980). The majority of studies also found that consumers expressed more satisfaction with life.

Additional studies support the first round of research. Many involved an expanded range of consumers, including veterans (Rosenheck, Neale, Leaf, Milsteind & Frisman, 1995), consumers in Great Britain (Marks, 1991), and homeless people with severe mental illness (Morse, Calsyn, Allen, Temelhoff, & Smith, 1992). After a review of these studies, Burns and Santos (1995) found strong evidence that ACT reduces the number of psychiatric hospitals days.

Further, most studies on the cost-effectiveness of ACT have either shown cost savings (Weisbred; 1980, Bond, et al, 1988; Nelson et al, 1995; Quinevan, 1995) or no cost difference (Jerrel and Hull, 1989). ACT has also been shown to be most cost effective when it is provided to consumers with a previous history of high use of mental health services (Rosenbeck, 1994).

Consumer Involvement

As in the delivery of all mental health services, consumers should be involved in every decision that affects them. Some consumer advocates have argued that ACT's supportive functions—such as assertive outreach, repeated crisis intervention, and the high degree of family involvement—have the potential to coerce consumers into unwanted services.

Thompson, Griffith, and Leaf address this concern in *Historic Review of the Madison Model of Community Care* (Thompson, 1990). In this article the authors discuss the evolution of the Wisconsin program, as well as strategies to lessen the possibility of such coercion and empower consumers. Such strategies include vocational rehabilitation, greater reliance on self-help groups, strong consumer advocacy programs and consumer-operated services, and enforcing consumers' rights to lodge formal complaints and refuse services.

As ACT programs expand, many consumer advocates are concerned that such services will increase the use of coercion in community-based services or outpatient civil commitment. Programs must address these legitimate concerns. This can be accomplished in a number of ways. For example, states and communities can establish advisory committees with strong consumer bases. Such committees could review program operations and conduct focus groups with ACT consumers to inquire about the kind of services being provided as well as the level of choice offered to individual consumers, and assess consumer satisfaction. ACT programs should also consider including consumer advocates as full team members.

The Village Integrated Service Agency provides services to 276 consumers with schizophrenia and other serious and persistent mental illness. Based on the ACT model, services are targeted to those consumers who are medium or high users of mental health services. Treatment teams consist of a psychiatrist, nurse, social worker, and paraprofessionals to coordinate services. These teams work with members in a collaborative, non-hierarchical style. Services focus on building strengths and abilities and de-emphasize illness and disabilities.

The Village takes the approach that clinician and consumer are equal partners in determining the services consumers receive. Consumers also develop a customized service plan by selecting from a list of psychiatric, employment, housing, health, financial and recreational options. Each service plan includes self-help, peer, and family support and community involvement.

During the initial three-year period of the Village program, members had significantly fewer hospital days than those in comparison groups and had significantly lower costs for inpatient care. In addition to other positive outcomes, members at the Village were significantly more satisfied than members of the comparison group (Meisel, 1996).

For more information, contact the Village Integrated Service Agency, 456 Elm Avenue, Long Beach, CA 90802. (562) 437-6717.

Recent, innovative designs in service delivery attempt to put consumers in greater control of their mental health services. As a result, many ACT programs have evolved to integrate direct service teams with consumer-based programs. In Long Beach, California, for example, the Village program "empowers adults with psychiatric disabilities to live, learn, socialize and work in the community," while at the same time integrates service teams and support. In states such as New Jersey, ACT teams include consumer advocates to ensure that programs incorporate consumer values and choices.

Through its Partners in Care Initiative, the National Mental Health Association (NMHA) is replicating the Village program in Wichita, Kansas, and is working with other communities to develop consensus and support for this type of program.

Evidence-Based ACT and Homelessness

The study, *Modifying the PACT Model to Serve Homeless Persons with Severe Mental Illness* (Dixon, 1995), analyzes a Baltimore program which adapted the ACT model to people who were homeless. The program was modified from the original ACT model in two ways. Smaller teams, limited to a clinical case manager, a psychiatrist and a consumer advocate, were used in order to better foster strong relationships with people who are homeless. In addition, this model offered a time-limited approach. This model demonstrated that

ACT principles of outreach and integrated care could be adapted to meet the needs of people who are without homes. If states are interested in replicating ACT programs to address the needs of homeless people with co-occurring mental health and substance abuse disorders, please consult the the brochure developed by CMHS in collaboration with NAMH-PAC on Mental Health and Homelessness. States may also want to obtain the National Alliance for the Mentally Ill's document, *The PACT Model of Community-based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start Up*.

Financing Evidence-Based ACT

As detailed by Robin Clark in *Financing Assertive Community Treatment* (Clark, 1997), almost all ACT programs are initially financed publicly through state and county funds. In the 1990s, state mental health authorities have used federal Medicaid funding to support an increasing share of ACT programs. Medicaid, combined with state and federal funds can cover the majority of people typically enrolled in ACT programs. Those not eligible for Medicaid are supported almost entirely from state or local sources. Under Medicaid, ACT services usually are financed under the Rehabilitation and Targeted Case Management service categories.

The financing of ACT programs has followed the trends of service delivery in the broader mental health system. This has meant an increased reliance on private contracting. In many states, mental health authorities do not control mental health-care reform. As a result, state Medicaid offices and other

agencies will have to be the focus of public education efforts concerning ACT. Additionally, financing for ACT has evolved over the years from direct provision of services to contracts for specific services by private providers.

As states and local communities continue to contract for ACT services, they should pay careful attention to specific language in each contract. In particular, clear outcomes and other quality assurances, consumer rights, and benefits covered should be closely reviewed. For more information about safeguards and important considerations in contracting mental health services, contact NMHA State Healthcare Reform Advocacy Resource Center or the PACT Technical Assistance Center at the National Alliance for the Mentally Ill.

Most importantly, ACT programs should not be funded at the expense of existing, well-working, community-based mental health services. Traditionally, ACT programs focus services on mental health consumers whose needs are not met by standard services. Instead of raiding existing programs, state budget surpluses might be used to finance ACT start up.

How to Use this Information

This document does not attempt to comprehensively address assertive community treatment. Instead, council members should use this as a primer or study guide before meetings on the issue.

To further examine ACT programs in your state:

- Gather the resources listed in this document and distribute them to council members.
- Host a planning meeting and invite stakeholders with expertise on assertive community treatment to address the topic. In addition to state and local chapters of the National Alliance for the Mentally Ill and the National Mental Health Association, include advocates and state mental health officials.
- Ask state mental health planning staff to provide an analysis of ACT programs and the number of people with needs that would benefit from ACT services within the state.
- Appoint a task force to work with state mental health staff to further explore the appropriateness of ACT programs. The task force should include mental health consumers and others who are knowledgeable about mental health services and representatives of other agencies such as housing and substance abuse.

Additional Information

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration Knowledge Exchange Network (KEN)
P.O. Box 42490
Washington, DC 20015
1-800-789-CMHS
http://www.mentalhealth.org
e-mail: ken@mentalhealth.org

The National Alliance for the Mentally Ill's PACT Technical Assistance Center
200 N. Glebe Road, Suite 1015,
Arlington, VA 22203-3754
Phone: (703) 524-7600
Fax: (703) 524-9094
Home Page: http://www.nami.org

The National Mental Health Association's Consumer Supporter Technical Assistance Center
1021 Prince Street
Alexandria, VA 22314
Phone: (703) 684-7722
Fax: (703) 684-5968
Home Page: http://www.nmha.org.
For technical assistance regarding matters of healthcare reform and systems change, contact NMHA's Advocacy Resource Center at (703) 838-7524.

Resources

The following documents form the basis for this brochure. Additional literature reviews are cited to build a greater understanding of ACT.

Recommended PACT Program Standards for New Teams. U.S. Center for Mental Health Service. (1998).

"Alternative to Mental Hospital Treatment," L. Stein and M. Test, Archives of General Psychiatry, 37: 392-297 (1980).

"Long-Term Care of Schizophrenia: Seven Year Results". Test, Knoedler, Allness., Kameshima, Burke, and Rounds. Paper Presented at the Annual Meeting of the American Psychiatric Association. (1994)

Evaluation of the Harbinger Program, 1982—1985, R. Mulder, Lansing, Michigan Department of Mental Health (1985).

"Psychiatric Hospital Versus Community Treatment: the Results of a Randomized Trial," J. Hoult, I. Reynolds, M. Charbonneau-Powis, et al., Australian and New Zealand Journal of Psychiatry, 17: 160-165 (1983).

"Intensive Case Management," [Letter], G.R. Bond, Hospital and Community Psychiatry, 41: 927-928 (1990).

"Multisite Experimental Cost Study of Intensive Psychiatric Community Care," R. Rosenheck, M. Neale, P. Leaf, R. Milstein, and L. Frisman, Schizophrenia Bulletin, 21(1): 129-140 (1995).

"Cost Effectiveness of Intensive Clinical and Case Management Compared with an Existing System of Care," J. Jerrell and T.-W. Hu, Inquiry, 26: 224-234 (1989).

"Issues in Estimating the Cost of Innovative Mental Health Programs," R. Rosenheck, M. Neale, and M. Frisman, Psychiatric Quarterly, 66: 1-23 (1994).

"A Historical Review of the Madison Model of Community Care," K. Thomspon, E. Griffith, and P. Leaf, Hospital and Community Psychiatry, 41: 634-641 (1990).

Independent Evaluator's Findings: Major Highlights. Chandler, J. Meilsel, T. Hu, M. McFowan, K. Madison. Psychiatric Services, 47, No. 12. 1137-1343. (1996).

The Pact Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start Up. D. Allness, W. Knoedler. The National Alliance for the Mentally Ill. (1998).

Making It Crazy: An Ethnographic Study of Psychiatric Clients in an American Community, S.E. Estroff (University of California Press, Berkeley, CA, 1981).

"What Happens to Patients After Five Years of Intensive Case Management Stops?" J. McRae, M. Higgins, C. Lycan, and W. Sherman, Hospital and Community Psychiatry, 41: 175-179 (1990).

Clinical Protocol for Case Management for Adults with Serious and Persistent Mental Illness, L. Giesler and M. Hodge (National Association of Case Management, Cincinnati, OH, 1997).

"Modifying the PACT Model to Serve Homeless Persons with Severe Mental Illness," L. Dixon, N. Krauss, E. Kernan, A.F. Lehman, B.R. DeForge, Psychiatric Services, 46: 684-688 (1995).

"Financing Assertive Community Treatment," Robin E. Clark, Administration and Policy in Mental Health, Vol. 25, No. 2 (November, 1997).

The National Association of Mental Health Planning And Advisory Councils (NAMHPAC)

The state mental health planning and advisory councils have joined together to form the National Association of Mental Health Planning and Advisory Councils (NAMHPAC). Federal law requires the establishment of mental health planning councils to review state applications for block grant funding, to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances, and to monitor and evaluate state mental health planning systems.

Although these activities are mandated, many states do not provide funding to support them. In many cases, this lack of funding combined with council members' often short tenures prevent these organizations from making their full impact on service delivery and consumer empowerment. NAMHPAC intends to provide technical assistance to these organizations in the areas of exemplary practices, organizational development, and information sharing. In addition, NAMHPAC provides a national presence on mental health policy issues on behalf of the state planning and advisory councils.

This brochure's simplified format is intended to provide planning and advisory councils with the essence of programs developed by the federal government, and to provoke questions that will lead to innovations in state planning processes.

Support from the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration made this brochure possible. We hope that each planning and advisory council member will closely read this document and use its information to develop the state plan for fiscal year 2001 and beyond. In addition, NAMHPAC will contact members of state councils to encourage them to use these materials, to evaluate how the materials were used, to identify topics for future pamphlets, and to gather suggestions for dissemination of such pamphlets.

CMHS and NAMHPAC are interested in your feedback. To make this and future best practices brochures useful to planning and advisory council members, please either cut along the dotted line or photocopy this page and mail it to NAMHPAC. Responses should be directed to: NAMHPAC, 1021 Prince Street, Alexandria, Virginia 22314-2971, telephone: (703) 838-7522, fax (703) 684-5968.

Suggestions for future best practices topics:

- ☐ Integrated Services
- ☐ Children's Systems of Care
- ☐ Adult and Juvenile Justice
- ☐ Consumer-Run Programs
- ☐ Employment
- ☐ Other _____

Suggested Changes in Brochure Format or Content:

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The National Association of Mental Health Planning and Advisory Councils

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